preferences were: None 13%; Islamic 4%; Christian 75%; and Other 8%. Six patients reported that they were not prescribed medication, so were not included in this analysis. Of the 47 who were on HAART 48.9% reported = 90% adherence in the past month. Mean adherence for these 47 was 74.7% (SD = 30.7). Four reported zero adherence. Mean adherence in the past month for behaviorally vs. perinatally acquired was 88% vs. 73.4%. Only perinatally infected adolescents, 14%, reported ever having stopped HAART medications because of a belief their HIV would be healed spiritually. Total mean Religious Coping on the RCOPE was 26.6 (SD = 6.3); mean Negative Religious Coping was 2.7 (SD = 3.5); mean Positive Religious Coping was 8.8 (SD = 2.5). Religious coping was not significantly correlated with adherence (Spearman r = -0.006, p = 0.97). The effect of Total Religious Coping on adherence was not significant (Spearman r = -0.07, p = 0.64), controlling for depression score (Mean = 8.7, SD = 8.1) and source of transmission. Daily spiritual experiences were not significantly associated with adherence. The majority of adolescents reported feeling God's presence some days to many times a day with almost half (41%) reporting feeling God's presence every day. However, this was not significantly correlated with adherence (r = -0.03, p = 0.86). This was the only item significantly different by transmission category on the BMMRS: 85.71% of behaviorally vs. 43.59% of perinatally infected adolescents reported feeling God's presence (p = 0.01), Adolescents with higher levels of organized religious practices did not have higher levels of HAART adherence (attendance at religious services: Spearman r = -0.11, p = 0.44; take part in other religious activities: Spearman r = 0.07, p = 0.63).

Conclusions: Contrary to our hypothesis no statistically significant associations were found between medication adherence and spirituality/religiosity. Small sample size is a limitation, although an item such as "ever stopped their medications because of belief in miracles" is clinically meaningful.

Sources of Support: National Institute of Nursing Research/NIH Award Number R01NR012711 and NIH National Center for Advancing Translational Sciences CTSI-CN UL1TR000075.

114.

WHO IS CARING FOR OUR HIV-INFECTED YOUTH? DISPARITIES ON ADOLESCENT-ORIENTED CLINICAL TRAINING OF PROVIDERS CARING FOR HIV-INFECTED YOUTH

Lana Lee, MD [1], Baligh Yehia, MD [2], Aditya H. Gaur, MD [3], Richard Rutstein, MD [4], Allison L. Agwu, MD [5].

[1]Johns Hopkins University; [2]University of Pennsylvania School of Medicine; [3]St. Jude Children's Research Hospital; [4]Children's Hospital of Philadelphia; [5]Johns Hopkins University School of Medicine.

Purpose: Youth aged 15-24 years living with HIV have a diversity of clinical care options available for HIV care in pediatric, adolescent, and adult-oriented clinic settings. HIV providers from multiple disciplines and specialties care for youth, however the adolescent training characteristics and availability of HIV providers by discipline and specialty training are not well-described. Using data from the HIV Research Network (HIVRN), a U.S. consortium of primary and subspecialty pediatric and adult HIV clinics, we examine the availability of adolescent-trained HIV providers to assess current needs for building an effective youth-friendly HIV workforce.

Methods: We reviewed the training and specialty profiles for 114 providers at 12 clinic sites of the HIVRN using clinic-level data solicited from a site survey. Providers' training/specialties were defined by their primary professional license and specialty certification, where applicable: Adult (adult nurse practitioner (ANP), internal medicine (IM) physician); Pediatric (pediatric nurse practitioner (PNP), pediatrician); Combined Specialty (family nurse practitioner (FNP) physician assistant (PA), internal medicine-pediatrics (MP) or family medicine (FM) physicians); and other (not specified). Adolescent training was defined as having completed a subspecialty fellowship in Adolescent Medicine; Pediatric-oriented training assumed any training in pediatrics and included all pediatric and combined specialty providers. Since paired provider-patient information was unavailable, we used the total numbers of youth enrolled at the 12 clinic sites between 2008 and 2011 to calculate the youth-to-provider ratios by specialty type to ascertain the density of providers available to youth by specialty categorization.

Results: Among 114 providers, 87 (76.3%) and 27 (23.7%) were caring for youth at 7 adult and 5 pediatric HIVRN clinics, respectively. No adolescent medicine subspecialty clinics are represented in the HIVRN. For the 946 HIV-infected 15 to 24-year-old youth receiving care between 2008 and 2011 (67% male; 69% Black; 46% with MSM HIV acquisition risk, 55% in adult clinics), there were 58 (50.9%) adult (7 ANPs, 51 IM physicians), 20 (17.5%) pediatric (6 PNPs, 14 pediatricians), 21 (18.4%) combined specialty (9 FNPs, 4 PAs, 8 MP physicians); and 15 (13.6%) other providers. Youth-to-provider ratios were 16:1 for adult, 47:1 for pediatric; 45:1 for combined specialty; and 6:1 for other providers. While 41 (40.0%) providers had pediatric-oriented training, only 3 (2.6%) providers had adolescent medicine fellowship training.

Conclusions: Providers from myriad professional specialties care for HIV-infected youth, however less than 3% of providers in this geographically diverse sample of primary and subspecialty HIV clinics have adolescent medicine subspecialty training. The lower youth-to-provider ratio for adult providers also suggests adult providers may have fewer opportunities to develop youth-oriented approaches to care. Subspecialists in adolescent medicine may play an important role in developing provider-targeted interventions that increase awareness of the unique needs of developing youth in order to build clinical capacity on youth-friendly approaches to HIV care.

Sources of Support: NICHD 5T32HD052459, NIAID 1K23AI084549, AHRQ 290-01-0012.

115.

THE IMPACT OF AVAILABILITY OF YOUTH-FRIENDLY SERVICES ON ENGAGEMENT IN CARE FOR HIV-INFECTED YOUTH: A STUDY OF THE HIV RESEARCH NETWORK

Lana Lee, MD [1], Baligh Yehia, MD [2], Aditya H. Gaur, MD [3], Richard Rutstein, MD [4], Allison L. Agwu, MD [5].

[1]Johns Hopkins University; [2]University of Pennsylvania School of Medicine; [3]St. Jude Children's Research Hospital; [4]Children's Hospital of Philadelphia; [5]Johns Hopkins University School of Medicine.

Purpose: Youth (15 -24 years old) living with HIV are at high risk of poor engagement in care compared to adults. At these transitional ages, youth are seen in either adult or pediatric care settings and may require youth-friendly approaches defined by the World Health Organization (WHO) as acceptable, accessible, appropriate, equitable, and effective to remain in care. In this cross-sectional study, we explored the availability of youth-friendly services that